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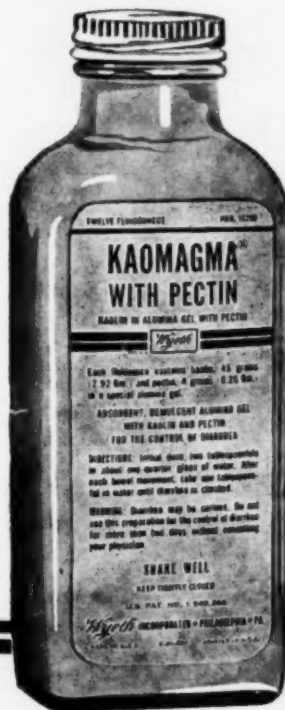
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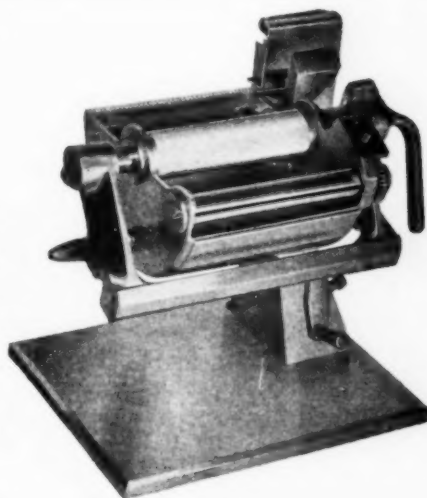
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THE SURGERY OF PEPTIC ULCER*

WM. G. SCHULZE, CH.M., F.R.C.S. (ENG.)

Cape Town

There must be few human diseases which have attracted as much attention in the literature, especially in the last decade, as gastro-duodenal ulceration, and it seems likely that the subject will continue to be discussed for some considerable time to come. While the pathology and the physiology of the lesion are fairly well understood, we are still somewhat in the dark about its etiology and treatment. From time to time, numerous theories have been postulated, and by degrees the less convincing have given way to newer ones based largely on experimental evidence and deduction. It seems clear that there is no one single cause for peptic ulceration, and that several factors, concerning mainly the physiology and the anatomy of the stomach and duodenum, play a varying role of importance.

Treatment. The present century has seen waves of enthusiasm for one kind of therapy and then another, and for one type of operation and then another. Someone very aptly remarked that every operation on the stomach was a success until it was found out! Nevertheless, to-day very considerable, especially surgical, progress has been made. Our cure rate to-day is better than it has ever been, and the incidence of post-operative complications and sequelae is lower than it has ever been.

But these excellent cure-rates and low mortality rates are the figures of the large hospitals and clinics overseas; they are the figures of the expert surgeon. These figures have not always been as good as they are now, and many factors have contributed to this improvement, not least among these being the closer co-operation between physician and surgeon in the assessment of cases, and the acceptance by the physicians of the important role the surgeon has to play.

The lines of treatment adopted in the larger hospitals and clinics in Great Britain and the United States of America are to-day more or less standardized. This article is a brief review of the present state of our knowledge of the etiology, and will discuss the indications for, and the types of surgical procedure adopted in the treatment of peptic ulcer and its complications.

Surgery plays an indispensable part in the treatment of duodenal ulcer, but it is nevertheless true that a considerable proportion of cases is cured effectively by medical means. At the Lahey Clinic in Boston, Dr. Richard Cattell told me that of 9,000 cases of duodenal ulcer treated at the clinic, no more than 10% came to

surgery. In England, statistics show that permanent cure of duodenal ulcer by means of conservative treatment alone, is not higher than 50%,¹ while other authorities there hold that less than 50% do well on medical treatment, and that fully one-third may be expected to relapse within four months of treatment.^{2,3}

Gastric ulcer, although pathologically similar in many respects to duodenal ulcer, must be considered in a totally different light. Gastric ulcer is a surgical condition. Duodenal ulcer never becomes malignant, and malignant disease of the first part of the duodenum hardly ever exists unless it be due to spread from adjacent organs. Between 3% and 5% of gastric ulcers become malignant, the so-called 'ulcer cancer'. Until fairly recently, very divergent views on the frequency of malignant change in gastric ulcer were reported from different clinics, but the position has to-day become clarified by universal adoption of certain well-defined criteria in the examination of histological specimens. In order to prove that a carcinoma did actually arise in a previous chronic gastric ulcer, it is necessary to demonstrate in the lesion the following points:—

(a) There must be a complete breach of the muscle coat beneath the ulcer, the gap being bridged by a mass of dense fibrous tissue.

(b) The muscularis mucosae must be drawn towards the circular muscle, with which it is often fused.

(c) There must be evidence of endarteritis obliterans in the region of the ulcer.

These points having been established, the lesion must show the following criteria of malignancy:—

(a) There must be epithelial growth at the margin of the ulcer only. The growth must not be an extension from surrounding areas towards the region of the ulcer.

(b) There must be submucous spread.

(c) There must be direct infiltration of the muscle, and this must not be confused with deep epithelial heterotopia—a common source of error.

(d) The epithelial cells must be neoplastic in appearance.

In addition to the possibility of malignant change in a gastric ulcer (and this is very small), what is of far greater importance, is the fact that in a large percentage of cases it is quite impossible to differentiate between a benign and a malignant lesion in the stomach without the aid of the microscope. In the larger clinics, the operability rate for gastric ulcer is in the region of 85% and no less than 20% of the gastric ulcers operated upon and considered benign at the time of the operation, are found by subsequent histological examination to be cancerous.⁴ It is this uncertainty in the diagnosis, coupled with the fact

* The references will be published at the end of the concluding part of this paper.

that the prognosis of carcinoma of the stomach (when it is diagnosed pre-operatively) is still so poor to-day, that gastric ulcer should always be regarded with great suspicion.

It is a well-known fact that a patient with a cancerous lesion may at times respond well to medical treatment, with considerable gain in weight, disappearance of all symptoms, and even radiological evidence of diminution in size of the ulcer. The X-rays may even show a disappearance of the crater, when in fact it is merely obliterated by exuberant cells tipped over the margin, or by oedematous granulation tissue. Even at gastroscopy the ulcer may appear to be healed, and yet at a subsequent examination a typical, actively growing carcinoma may be found in its place. It is only by repeated examination that a gastric ulcer can be proved to be benign.

INCIDENCE AND FREQUENCY

Chronic ulcers are more frequent in the duodenum than in the stomach. It is usually stated that duodenal ulcer is three times as common in men as it is in women, although in certain districts it is as much as 19 times as common. Gastric ulcer is said to affect the sexes equally. The disease is common in the Western hemisphere and in India. It is extremely uncommon in countries where the diet is mainly vegetarian, e.g. China.

Acute ulcers are most common between 15 and 25 years, while chronic ulcers occur most commonly between 20 and 45 years of age.

Acute ulcers are usually multiple and are diffusely distributed, but occur mainly in the pyloric antrum and the duodenum. Chronic ulcers are single, as a rule, although 'kissing' ulcers are not uncommon in the duodenum, and about 20% of patients present with lesions in both stomach and duodenum.

In Great Britain it is estimated that at least 10% of the population suffers from peptic ulceration at some time or another.

Chronic duodenal ulcers occur almost exclusively in the most proximal part of the duodenum. An ulcer in the second or third parts must be looked upon with suspicion. At least 82% of gastric ulcers occur in the vertical part of the lesser curve, and the immediately adjacent anterior and posterior walls; only about 12% of simple ulcers are found in the pyloric antrum. At least 66% of gastric carcinomas begin in this latter area, and it is for this reason that an ulcer occurring in the pre-pyloric inch should be regarded with extra suspicion.

ETIOLOGY

Peptic ulcer will arise only in those areas of the gastrointestinal tract exposed to the action of the gastric juices. Thus it may occur in any of the following situations:

- (a) In the stomach.
- (b) In the duodenum.
- (c) In the lower oesophagus following operations such as oesophago-gastrostomy for the relief of achalasia of the oesophagus.
- (d) In the same situation in cases of diaphragmatic hernia where the normal relationship of diaphragm to cardia is disturbed, and gastric juices have access to the oesophagus.
- (e) In the jejunum immediately adjacent to the stoma of a gastro-enterostomy.

(f) In the small intestine adjacent to areas of heterotopic gastric mucosa, e.g. Meckel's diverticulum.

There is, however, a great deal more to it than the mere presence of acid and pepsin. Peptic ulcer never occurs naturally in lower animals, although their gastric

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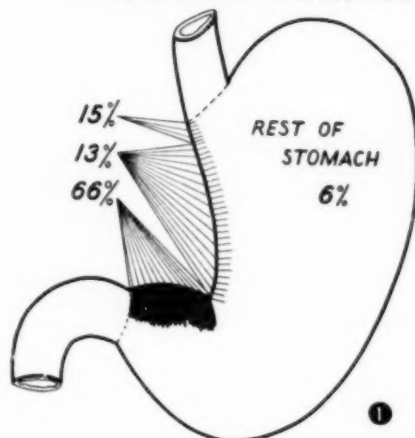


Fig. 1.

PEPTIC ULCER INCIDENCE

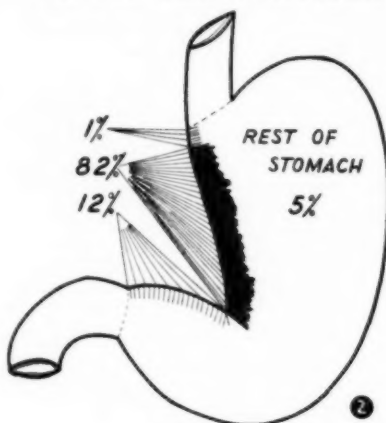


Fig. 2.

juices contain a high level of acid; nor does the vast majority of the human population suffer from ulceration although the incidence of achlorhydria in young adults is probably no more than 5%. Peptic ulcer cannot be

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explained by one cause alone. It is generally agreed that many factors must contribute to its genesis, and that these various factors must play a varying role of importance in different cases.

Acute ulcers are known to occur in association with certain toxic states such as tuberculosis, pyorrhoea, burns, tonsillitis, puerperal infections and peritonitis; but it is quite certain that only a negligible proportion of these may persist and proceed to chronic ulceration.

It seems fairly clear that chronic ulceration is usually not due to extraneous causes such as toxins and infections, but that its origin and progress is intimately bound up with a disturbance of gastric physiology, while its location is dependent on certain anatomical considerations.

Gastric ulcer occurs almost always along the vertical part of the lesser curvature, while duodenal ulcer begins almost invariably in the duodenal bulb, i.e. the most proximal part of the duodenum, also referred to as the duodenal cap. It must be noted that this bulb or cap is not the whole of the first part of the duodenum, and

body and fundus; but in the latter area they are much less numerous than in the body of the stomach. An alkaline secretion is produced by the glands in the pyloric antrum, and also by a narrow strip of mucosa at the cardiac orifice. The antral mucosa produces in addition a hormone which, when activated by the products of gastric digestion, passes into the portal circulation, returning later in the systemic arterial supply of the stomach to stimulate secretion of acid and pepsin by the principal glands of the stomach. This mechanism, therefore, comes into effect about half an hour after the ingestion of food, and it continues for as long as food is being digested in the stomach. It ceases normally when the stomach is empty. In all probability this hormonal mechanism is the main excitator of gastric secretion in the normal human subject.

Neurogenic secretion of acid and pepsin occurs normally only at the commencement of a meal, being provoked by the sight, smell and taste of food (particularly the latter) and especially if this be agreeable. This mechanism operates normally until the appetite is sated, at which time the hormonal secretion takes over.

It has long been known that physical stimulation of the parasympathetic pathways in the hypothalamus, brain stem, vagus trunks and vagus nerves will lead to hypersecretion, hyperacidity, hypermotility, and may actually lead to mucosal ischaemia and ulceration. Physical influences governing the vegetative centres in the hypothalamus have been shown to produce an identical effect. Vagus section in the human being, as in the dog, produces a marked fall in the quantity and level of acid secretion.

HYPERSECRETION

Ninety per cent of duodenal ulcer patients have hyperchlorhydria, and duodenal ulcer never occurs in the presence of achlorhydria. Normal people in the prime of life probably secrete most acid and are in fact hyperchlorhydric when they are at their fittest, but they do not develop duodenal ulceration. Their gastric secretions behave in a physiological manner, high levels of acid and pepsin being poured out during meal times, but these cease when the stomach is empty.

The duodenal ulcer patient, on the other hand, pours out his excessive secretions at all times, even and especially between meals and during sleeping hours. This is probably one of the most important facts in connexion with the genesis and the progress of a duodenal ulcer. It matters not so much what level the acid curve attains. It is the quality of the night secretion which is of real importance.

Hitherto the acid component of the gastric juices has received most attention, probably on account of the ease with which its presence and quantity can be determined as compared with pepsin. Schofield⁵ has shown in his recent experiments on dogs that vagal stimulation produces a profound increase in pepsin secretion, that the secretion of acid and pepsin are completely independent of each other, that pepsin is secreted to an equal extent in the resting stomach (or stomach pouch), whether this is innervated or denervated, and that the normal increase in pepsin output in response to feeding will occur only in the innervated pouch. The addition of a small amount of acid to the pepsin converts this into a powerful tissue-destroying agent.

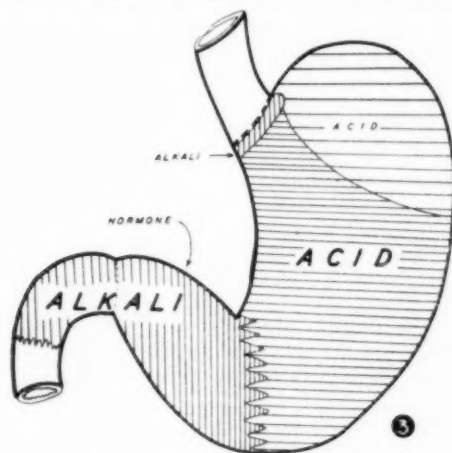


Fig. 3. Showing main gastric secretions.

it is interesting that the anatomy of this part is different from that of the rest of the duodenum. The mucous membrane here is smooth and adherent to the muscular coat which in turn is poorly developed in the region of the cap. During gastric digestion there is always a pool of acid chyme to be found in the cap, but not in the rest of the duodenum, which empties itself rapidly.

The mucosa of the stomach along the *Magenstrasse* also has certain peculiarities. In this region it is flat and it is firmly adherent to the underlying muscle coat, while the rest of the stomach is lined by mucosa which is heaped up into thick tall folds and moves freely over the muscle coat. These folds are tallest over the body of the stomach, becoming flatter and less numerous in the region of the fundus of the stomach.

Acid and pepsin are secreted by the principal glands of the stomach, distributed over the greater part of the

FAILURE OF NEUTRALIZATION

Until recently it was held that neutralization of the gastric juices between meals occurred as a result of regurgitation of duodenal contents into the stomach. There is no evidence that this occurs normally and, in fact, there is no evidence that any part of the human gastro-intestinal tract works backwards under normal conditions; but neutralization must and does occur in the normal stomach. An alkaline mucus is secreted by the pyloric and cardiac glands, but it would appear that all the mucosal cells in the stomach are capable of protecting themselves against digestion. The exact mechanism of this process is as yet not fully understood, but it is clear that some buffering mechanism must be continually at work.

In the case of a peptic ulcer, it is only a very small area of the gastric mucosa which is digested, the remainder being quite normal. It is possible that an alkaline mucus is secreted by each cell with which it protects its surface, and it may be that a local failure of the ability to secrete this substance is an important factor in the etiology of ulcer. Immediately after death, this mechanism ceases to operate as evidenced by the rapid digestion of gastric mucosa. It may be that the greater part of the stomach mucosa is protected from ulceration by being constantly bathed by the buffering substances in the stomach, while the lesser curve is made more vulnerable to digestion by the constant trickle of acid juices along its surface, situated as it is well above the gastric sump.

TRAUMA

It is not difficult to imagine that the delicate mucous membrane of the stomach must receive abrasions from time to time from solid and rough particles of food which we eat. The vast majority of these, and especially those situated on the loosely attached mucosal folds, will heal rapidly while those sustained by the tightly adherent mucosa of the *Magenstrasse*, along which in any event the major part of the food passes, will take much longer to heal. If then, in addition, the stomach is hypermotile, the muscle is in spasm, and there is an excess of acid and pepsin secretion, especially when the stomach is empty, it would seem that digestion of such an abrasion could proceed forthwith.

SPASM

Spasm and hypermotility seldom accompany gastric ulceration, but they are a constant feature of duodenal ulcer. Stomach motility is increased by stimulation of the vagus nerves, and the hypermotility and rapid emptying which are characteristic of duodenal ulceration, are no doubt due to overaction of the vagus nerves and its centres in the hypothalamus. It can be shown, however, that the presence of excessive acid alone will cause the stomach and duodenal muscle to go into spasm. Dodds *et al.*,⁶ in their experiments with pituitrin, showed that spasm alone can produce an ulcer, even in the absence of acid. Spasm of the bowel muscle causes an ischaemia of the overlying mucosa by constriction of the vessels supplying the mucosa. Starr and Steinberg⁷ have shown that jejunal ulcer will always occur when the jejunum is exposed to undiluted gastric juice, but that this ulceration

can be prevented by preliminary stripping of the muscle coat from the mucosa.

Babkin showed that the vagus nerve endings are most numerous along the lesser curve of the stomach, and in the duodenal bulb.⁸ It is possible then that hypermotility is maximal in these areas where ulceration is common, and it may be that spasm and hypermotility play a leading part in the genesis of ulceration.

THE ULCER DIATHESIS

It has long been noted that the duodenal ulcer patient belongs to a well-defined psychological group. He is usually hypersthenic, emotional, sensitive, energetic, conscientious, above normal intelligence, and he has a small, hypermotile stomach which empties rapidly and which, after emptying, continues to secrete acid and pepsin. Gastric ulcer patients are of a different type and their mental make-up is less characteristic. Usually they are listless, feeble patients, often undernourished, and they have a long J-shaped stomach with tension on the lesser curve which lies high above the buffered sump of the stomach.

There seems little doubt that the most important feature regarding duodenal ulcer patients is the abnormal activity of the parasympathetic supply of the stomach. This is responsible for the hypermotility and rapid emptying, the excessive gastric secretion with its high acid level and, most important of all, the continuation of gastric secretion between meals and during sleeping hours. There seems to be little evidence that the hormonal secretion of acid is at fault in peptic ulcer patients, although there are noted authorities who believe this.⁹

SMOKING

Much has been written about smoking in relation to gastro-duodenal ulceration, and it would not be an exaggeration to say that there are some who would attribute ulceration directly to smoking. At the present time, it is generally accepted that the dangers of smoking are probably exaggerated. It is perfectly true that smoking has a slight stimulating effect on gastric secretion, and it is for this reason that smoking on an empty stomach is not to be recommended.

A large number of ulcer patients are smokers but a far greater proportion of the smoking population does not develop ulceration, and in addition there is a great number of ulcer patients who have failed to cure their ulcers by complete abstinence. The incidence of duodenal ulceration in men has risen sharply since the termination of World War I, while the tobacco habit amongst men is no higher to-day than it was then. On the other hand there has been no appreciable increase of duodenal ulcer amongst women during this period, in spite of the enormous increase of smokers. The important thing in the ulcer patient is the overactive parasympathetic and its centres in the hypothalamus. His smoking habit, or excessive smoking, is merely an incident, and the physician finds it much easier to blame the smoke and to forget to treat the hypothalamus.

(To be continued)

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EDITORIAL

THE CRIMINAL'S RESPONSIBILITY

It is with great interest that we note the appearance of *The British Journal of Delinquency*¹ which is devoted to the study and treatment of delinquent behaviour. Included on the editorial board is a distinguished group of authorities from the medical profession. It is reasonable to expect that psychiatric study of the origins and prevention of delinquency will result in the more adequate treatment of delinquents and consequently diminish the amount of harm they do to society.

Delinquency is more a social than a medical problem. Few informed persons still cherish the belief that crime is always a sign of sickness and that the criminal invariably deserves not punishment but clinical treatment. In Britain the crime incidence decreases in each successive age group and the number of males who commit crimes is eight times as great as the number of females.² These figures make unlikely the belief that crime is due to disease, for:

(a) The number of boys mentally abnormal at the age of nine is by no means double the number of those aged 19;

(b) There is no evidence that eight males are mentally abnormal to each girl or woman.

The problem of controlling and repressing anti-social behaviour arose with the earliest forms of society and during the centuries laws have been evolved with corresponding punishments for those who break them. In point of fact there is a retributive element in the punishment; but the punishment, in addition, should have a reformatory aspect, and certainly should not contribute to further crimes. While imprisonment has an undeniably punitive effect, it has little reformatory value. Our penal system has the advantage of deterring the normal citizen from breaking the law and removing from society those criminals who threaten the security of their fellows; the main misfortune is that imprisonment turns many delinquents into habitual criminals.

In spite of evidence to the contrary, there remains in many legal minds the erroneous attitude that the harsher the sentence and the longer the imprisonment, the more remedial will be its effect. This belief is not in agreement with the facts.

VAN DIE REDAKSIE

DIE VERANTWOORDELIKHEID VAN DIE MISDADIGER

Dit is met groot belangstelling dat ons kennis neem van die verskyning van *The British Journal of Delinquency*¹ wat gewy is aan die studie en behandeling van misdadige gedrag. Die redaksieraad sluit 'n gesiene groep gesaghebbendes uit die mediese beroep in. Daar kan met redelikheid verwag word dat psigiatriese bestudering van die oorsprong en voorkoming van misdadigheid sal uitloop op die toereikender behandeling van oortreders en gevolglik die hoeveelheid kwaad sal verminder wat hulle die maatskappy berokken.

Misdadigheid is 'n probleem wat meer maatskaplik as geneeskundig is. Min ingeligte persone hang nog die mening aan dat misdaad altyd 'n teken van siekte is en dat die misdadiger sonder uitsondering kliniese behandeling en nie straf nie verdien. In Brittanje verminder die misdaadsyfer met elke ouderdomsgroep en die aantal manlikes wat misdade pleeg is agt maal groter as die aantal vroulikes.² Hierdie syfers maak die juistheid van die mening dat misdaad aan siekte te wyte is, oonwaarskynlik omdat:

(a) Die aantal seuns wat by die ouderdom van nege verstandelik abnormaal is, sekerlik nie tweemaal so groot is as dié by die ouderdom van 19;

(b) Daar is geen getuienis dat vir elke meisie of vrou agt manlikes verstandelik abnormaal is nie.

Die probleem van die beheer en onderdrukking van anti-sosiale gedrag het by die vroegste vorms van die maatskappy ontstaan en deur die eeue is wette ontwikkel met ooreenstemmende strawwe vir dié wat hulle oortree. In werklikheid is daar 'n vergeldingselement in die straf, maar die straf moet daarbenewens 'n verbeteringsaspek hê en moet sekerlik nie tot verdere misdade bydra nie. Terwyl tronkstraf onteenseglik 'n strafuitwerking het, het dit weinig verbeteringswaarde. Ons strafstelsel het die voordeel dat dit die normale burger van oortreding van die wet weerhou en daardie misdadigers wat die veiligheid van hulle medeburgers bedreig, uit die gemeenskap verwyder; die vernaamste tekortkoming daarvan is dat tronkstraf baie oortreders in gewoontemisdadigers verander.

Ten spyte van getuienis wat die teendeel bewys, bestaan daarby baie regsgeleerdes die verkeerde houding dat hoe strenger die vonnis en hoe langer die tronkstraf, hoe verbeterend sal die uitwerking wees. Hierdie mening strook nie met die feite nie.

1. *The British Journal of Delinquency* (1950): Vol. 1, No. 1, London: The Institute for the Study and Treatment of Delinquency and Baillière, Tindall & Cox.
2. East, W. N. (1944): *J. Ment. Sci.*, **90**, 382.

1. *The British Journal of Delinquency* (1950): Deel 1, No. 1, London: The Institute for the Study and Treatment of Delinquency en Baillière, Tindall en Cox.
2. East, W. N. (1944): *J. Ment. Sci.*, **90**, 382.

But it is not only with the reformation of suitable cases of delinquency that forensic psychiatry is concerned. The psychiatrist also stands in relation to the law when the culpability of the delinquent is being assessed. Some hundreds of years ago the principle was introduced into English Common Law that it was necessary to take account of the mental processes of an accused person ('a man's act does not make him guilty, unless his mind is also guilty'). As the law has become more humane, the life circumstances of convicted persons have been taken more into account. The emphasis has to some extent been removed from the crime and focussed on the offender and his background. Medical interest in the aetiology of crime, since the Swiss physician Plater³ in 1746 produced his *Program Wherein it is Demonstrated that Physicians Ought to be Heard about the Insane and Mad*, has contributed greatly to this change in legal outlook.

Although to-day the medical practitioner thinks increasingly in terms of the community, his primary concern remains with the individual. Psychiatric knowledge makes it extremely doubtful that a person may be held entirely responsible for his actions. Human behaviour, from infancy to adulthood, fulfills certain very definite instinctual urges and drives. Even if a man knows the wrongness of an act, he may not be able to stop himself from doing it. The extent of a delinquent's responsibility is a major contemporary medico-legal problem. Sir Norwood East has repeatedly drawn attention⁴ to the increasing scepticism with which psychiatric evidence is being received in the Courts. Lord Cooper⁵ has stated: 'The psychiatrist cannot complain if those responsible for public administration of law subject his arguments to exactly the same tests as would be applied to those of anyone else. The lawyer is not ready to accept the principle that there is a section of the community chosen by medical men whose members are free to commit crime with limited liability'.

Although the suggestion is that medical witnesses, in hesitating to credit a wrongdoer with full responsibility for his crime, are often careless of their duty to safeguard society, the vast importance of the psychiatric approach in elucidating criminal behaviour is well recognized. Henderson⁶ has stated that the conflict which produces criminal acts in the case of delinquents is very much the same type as that which produces psychoneurosis.

Research into the early development of delinquent children has shown the crucial importance of early experiences within the family; while one child may react to an unsatisfactory family situation by a neurotic breakdown, another reacts by delinquency.⁷

The medical profession can affirm the valuable con-

Maar dit is nie slegs met die verbetering van geskikte gevalle van oortreding waarmee geregtelike psigiatrie gemoeid is nie. Daar is ook 'n verband tussen die psigiater en die wet wanneer die verantwoordelikheid van die oortreder bepaal word. Enige honderde jare gelede is in die Engelse gemeenereg die beginsel ingevoer dat dit nodig is om die verstandelike prosesse van 'n aangeklaagde in aanmerking te neem ('n persoon se daad maak hom nie skuldig nie tensy sy verstand ook skuldig is'). Soos die wet minder streng geword het, is die lewensomstandighede van veroordeeldes meer in aanmerking geneem. Die klem is in 'n mate van die misdaad weggeneem en op die oortreder en sy agtergrond gelê. Sedert die Switserse geneesheer, Plater,³ in 1746 sy *Program Wherein it is Demonstrated that Physicians Ought to be Heard about the Insane and Mad* gelewer het, het geneeskundige belangstelling in die etiologie van misdaad veel bygedra tot hierdie verandering in resopsvatting.

Alhoewel die geneesheer vandag meer en meer in terme van die gemeenskap dink, stel hy nog veral belang in die enkeling. Kennis van die psigiatrie maak dit uiters onwaarskynlik dat 'n persoon as heeltemal verantwoordelik vir sy daade beskou kan word. Menslike gedrag voldoen vanaf die kinderjare tot by volwassenheid aan sekere baie besliste instinktiewe drange en neigings. Selfs wanneer 'n persoon bewus is van die verkeerdheid van 'n daad, mag hy nie in staat wees om homself daarvan te weerhou nie. Die omvang van die oortreder se verantwoordelikheid is 'n belangrike hedendaagse medies-geregtelike probleem. Sir Norwood East het herhaaldelik die aandag gevestig⁴ op die toenemende skeptisisme waarmee psigiatriese getuienis in die Howe aangehoor word. Lord Cooper⁵ het verklaar: 'Die psigiater kan nie kla wanneer diegene wat vir openbare administrasie van die wet verantwoordelik is, sy argumente aan presies dieselfde toetse onderwerp as wat op dié van enigiemand anders toegepas word nie. Die regsgeleerde is nie bereid om die beginsel te aanvaar dat daar 'n deel van die gemeenskap deur die geneeskundiges uitgekies is waarvan die vry is om misdaad met beperkte verantwoordelikheid te pleeg nie'.

Alhoewel daar te kenne gegee word dat mediese getuienis, wanneer hulle aarsel om volle verantwoordelikheid aan die oortreder toe te skryf, dikwels hulle plig versuim om die gemeenskap te beskerm, word die ontsaglike belangrikheid van die psigiatriese benadering by die verklaring van misdadige optrede taamlik algemeen erken. Henderson⁶ het verklaar dat die botsing wat kriminele daade by oortreders veroorsaak sterk ooreenkom met die tipes wat psigoneuroses veroorsaak.

Navorsing na die vroeë ontwikkeling van misdadige kinders het die uiterste belangrikheid van die vroegste ondervindinge binne die gesin aangetoon; terwyl die een kind deur neurotiese instorting op onbevredigende gesinsomstandighede reageer, mag 'n ander deur misdadigheid reageer.⁷

Die mediese beroep kan die waardevolle bydrae bevestig wat bestudering van die psigiatrie tot die begrip van

3. Quoted by Wertham, F. (1949): *The Show of Violence*. London: Victor Gollancz Limited.

4. East, N. (1950): *Med-Leg. J.*, **18**, 10.

5. Lord Cooper (1946): *J. Ment. Sci.*, **92**, 701.

6. Henderson, D. K. (1950): *Brit. Med. J.*, **2**, 311.

7. Stott, D. H. (1950): *Delinquency and Human Nature*. Carnegie United Kingdom Trust.

3. Aangehaal deur Wertham, F. (1949): *The Show of Violence*. Londen: Victor Gollancz Beperk.

4. East, N. (1950): *Med-Leg. J.*, **18**, 10.

5. Lord Cooper (1946): *J. Ment. Sci.*, **92**, 701.

6. Henderson, D. K. (1950): *Brit. Med. J.*, **2**, 311.

7. Stott, D. H. (1950): *Delinquency and Human Nature*. Carnegie-trust van die Verenigde Koninkryk.

tribution which psychiatric study can make to the understanding of delinquency and shares the public concern at its increasing incidence. But we must admit that crime cannot yet be controlled substantially by psychological treatment. Many delinquents have personalities which cannot be reconstructed, or even changed to more socially acceptable forms. There is very little merit in the contention that the judge should be replaced by the doctor and the prison by the hospital.

misdadigheid kan lewer en deel die sorg van die publiek oor die toenemende voorkoms daarvan. Maar ons moet erken dat misdaad nog nie in aansienlike mate deur sielkundige behandeling beheer kan word nie. Baie oortreders het persoonlikhede wat nie opnuut opgebou kan word nie of selfs tot vorms verander kan word wat vir die gemeenskap meer aanvaarbaar is nie. Daar steek uiters min in die bewering dat die regter deur die geneesheer en die gevangenis deur die hospitaal vervang moet word.

MUCO-CUTANEOUS-OCULAR SYNDROME

REPORT ON A CASE TREATED WITH AUREOMYCIN

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The term 'Muco-Cutaneous-Ocular Syndrome' was suggested by Robinson and McCrumb¹ to cover the whole group of variants of erythema multiforme exudativum. They suggest that there are so many points of similarity between 'Stevens-Johnson disease'² and Behcet's disease³ with its 'triple symptom complex' of congenital, oral and ocular lesions, Reiter's disease⁴ with its urethritis, conjunctivitis and arthritis, and ectodermosis erosiva pluriorificialis (Fiessinger)⁵ that they are probably all variants of erythema multiforme exudativum, excepting possibly the so-called Reiter's disease. According to present-day conception, all the above entities differ decidedly from the original descriptions.¹

Klauder⁶ classifies erythema multiforme into symptomatic (due to infection, drugs, sera, etc.) and idiopathic types, the latter being due to a virus.

It is possible that the symptomatic form may also be of virus origin, the causal factors 'tilting the delicately balanced virus-host relationship' in favour of the virus.

Figs. 4 and 5 illustrate a typical case of erythema multiforme due to Sulphadiazine in a girl of 8 years of age admitted to the Dermatological wards of the Groote Schuur Hospital.

The patient was very ill and had a high temperature. The raised, red, bullous lesions on the legs were confluent and typical of a drug rash. The mouth and eyes were also involved.

It may be that, at one end of the scale, there is a disease in its own right (as apart from the syndrome described by Stevens-Johnson) with muco-cutaneous-ocular lesions which have no accountable cause. The cutaneous lesions are perhaps less confluent and more haemorrhagic than in the typical drug rash. There may be lung consolidation.

At the other end of the scale there is the typical erythema multiforme due to a drug, in this case Sulphadiazine (Figs. 4 and 5). Other cases perhaps are not typical of either condition, but show many features of both.



A case of the idiopathic form of erythema multiforme gravis, treated with aureomycin, is now described.

A Coloured male (Malay) aged 28 and employed as cement worker, was referred by Dr. A. Jowell.

On 6 March 1950 he complained of a feeling of lameness in the knees. The next morning grouped vesicles, bullae, and

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wheals were noted over his abdomen. These persisted throughout the following day, and were followed by a bullous eruption on the face, particularly at the angles of the eyes.

On the evening of 8 March more bullae and vesicles appeared on the abdomen and the scrotum. He complained of dysuria and also of a very severe headache.

On 10 March more bullae appeared on the face, eyelids and lips. The next day he was seen by Dr. Lang, who admitted him to his wards at the Groote Schuur Hospital. By now bullae had appeared on the arms and legs.

2,760 per c.mm., of which 49% were polymorphs, 26% lymphocytes, and 25% monocytes.

On 13 March the patient had not improved and had become delirious.

On 14 March his bladder was distended, no urine having been passed for 18 hours. This retention had been preceded by extreme dysuria. The patient was catheterized and an indwelling catheter was inserted. His general condition remained the same. He was extremely ill with a temperature of 101° F and pulse rate of 115.



On admission on 11 March, the patient presented a most florid appearance (Figs. 1, 2 and 3) and was extremely ill with severe pyrexia of 102° F and headache. The eyelids were oedematous with denuded areas following rupture of the bullae, and there was a purulent conjunctival discharge; the eyelids tended to stick together. There was extreme photophobia. There were ulcerated areas on the lips, gums, palate and tongue, producing a purulent, blood-stained, watery saliva. Between the bullae inside the cheek there were bluish-white areas. There were also very large bullous and denuded areas over the back, chest and abdomen and scrotum.

Progress: The patient was immediately put on penicillin intramuscularly, 500,000 units daily. On the next day, i.e. 12 March 1950, the temperature rose to 102° F and pulse rate to 112 per minute.

A blood examination showed that the white cell count was

Numerous new vesicles had now appeared and there was no response to penicillin. There were many vesicles and bullae on the chest, abdomen and legs. It was decided, therefore, in view of his very serious general condition, to put him on Aureomycin, which was given him by mouth, one 250 mg. capsule six-hourly. The penicillin was stopped.

On 15 March his temperature was slightly down but his general condition and appearance were about the same.

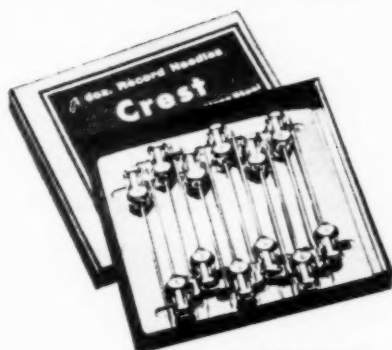
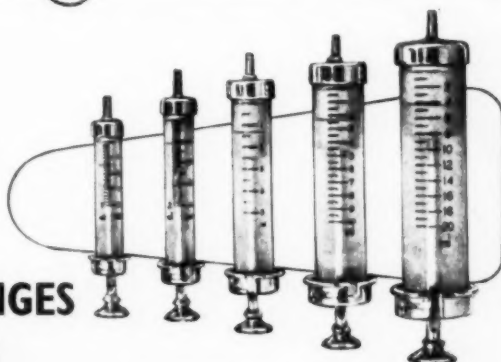
On 16 March the blood count was as follows: red cells 3.48 million per c.mm., white cells 5,440 per c.mm. (The white cell count had therefore risen.) The differential count showed polymorphs, 55%; lymphocytes, 33%; monocytes, 10%, and eosinophils 2%.

Throat Swab: The smear revealed numerous gram negative bacilli and coccil bacilli and scanty gram-positive bacilli. On culture, a heavy growth of coagulase-positive *Staphylococcus*



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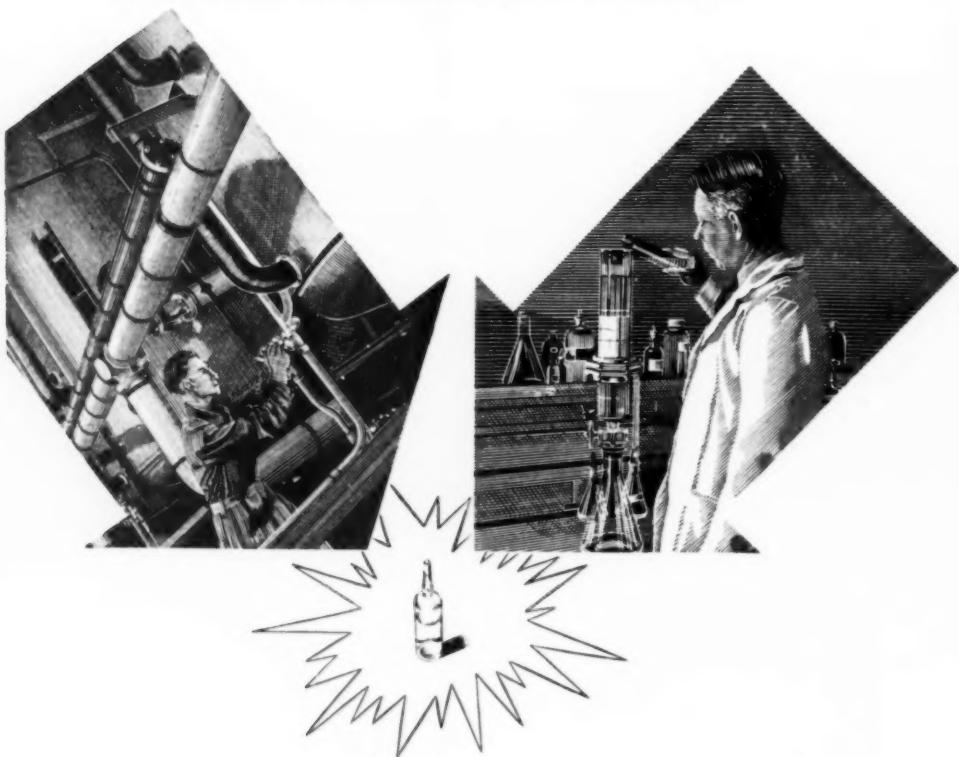
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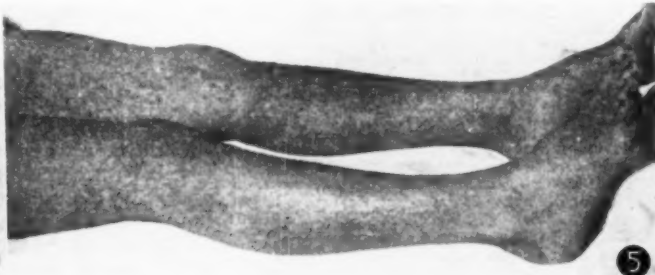
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aureus, sensitive to streptomycin, not to penicillin. The fluid from the bullae showed no organisms and no growth on culture.

On 18 March, four days after starting aureomycin treatment, the temperature came down to 99° F and the pulse rate from 115 to 100 beats per minute. He was seen by Dr. Scher who advised bladder irrigation to prevent bladder infection; there was some pain over the hypogastrium. The patient was now coughing and complained of some pain in the chest. X-ray of the chest was normal.

By 20 March the temperature and pulse rate were normal, but certain fresh lesions had appeared on the chest and abdomen. His general condition, however, had improved dramatically.



On 24 March there were still septic areas on his scrotum, but the meatal lesions had improved so much that the indwelling catheter was now removed. The lesions all over the body were now in the healing stage.

On 26 March the Aureomycin was stopped, but the patient complained of dysuria and later complete inability to pass urine. He was catheterized and the catheter was tied in.

On 31 March he was cystoscoped. No bullae were seen in the bladder; there was some degree of scarring in the region of the trigone.

COMMENT

There seems to be no reasonable doubt that Aureomycin had a markedly beneficial effect in this case, the temperature being normal five days after the commencement of therapy. The dramatic general improvement within 48 hours was striking, the patient having been moribund at the commencement of therapy.

Several writers have now reported success with Aureomycin in this condition.

Robinson⁷ in discussing Aureomycin in the treatment of some dermatoses, reported rapid healing in eight out of nine cases of erythema multiforme, in which there was no recurrence in 12 weeks. The lesions involuted within three to eight days.

Church⁸ reports a case of erythema exudativum multiforme and pneumonia treated with Aureomycin. The patient was given Aureomycin in 1 gm. dosage every six hours for four days. The response was dramatic.

Lynas⁹ discusses the use of Aureomycin in Stevens-Johnson syndrome, and describes a man of 21 who had a lesion which appeared typical of Stevens-Johnson syndrome; before admission to hospital the patient had received six injections of penicillin and $\frac{1}{2}$ million grains of ascorbic acid. Treatment was continued for three days with no improvement, the temperature remaining at 100° F and the mucosal lesions continuing to cause severe distress. Three days after the patient was admitted

Aureomycin 1 gm. was given six-hourly. Within 12 days the temperature became normal, and remained so. The following day the mouth showed definite clinical improvement, and two days later he was quite well and Aureomycin was discontinued. A week later he was discharged.

Loewenthal, Marais and Ruskin¹⁰ report two cases of so-called Stevens-Johnson syndrome which were treated with Aureomycin. Recovery occurred promptly in both, and they suggest that Aureomycin acts as a specific remedy in this disease.

Herrell *et al.*¹¹ mention that amongst the conditions

responding satisfactorily to Terramycin was erythema multiforme.

One patient with severe erythema multiforme appeared to improve after the administration of Terramycin. The lesions underwent rather rapid involution; the bullae did not become haemorrhagic as was expected.

Persky¹² also mentions a case of so-called Stevens-Johnson syndrome treated with 750 mg. of Aureomycin four-hourly until 14,000 mg. had been given over a period of three days, improvement occurring when therapy was started. A comment made with regard to this case was that Stevens-Johnson disease is not an entity, but one type of erythema multiforme.

SUMMARY

1. A case of erythema multiforme gravis responding to Aureomycin is described.
2. Reference is made to other cases in the literature which were treated similarly.
3. Attention is drawn to the similarity between the muco-cutaneous-ocular syndromes.

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Echoes from the Past

ARCHIVES FOR A HISTORY OF MEDICINE IN SOUTH AFRICA

Hottentots and Small Pox at the Cape of Good Hope

From *A Discourse on the Small Pox and Measles* by Richard Mead, Fellow of the Royal Colleges of Physicians at London and Edinburgh, and of the Royal Society, and Physician to His Majesty. London: Printed for John Brindley, Bookseller and Stationer to His Royal Highness the Prince of Wales, in New Bond Street. MDCCXLVIII. (Chapter 1, pp. 8—12).

But to return to the small pox. I really take this disease to be a plague of its own kind, which was originally bred in *Africa*, and more especially in *Ethiopia*, as the heat is excessive there; and thence, like the true plague, was brought into *Arabia* and *Egypt*, after the manner above-mentioned.

Now if any one should wonder why this contagion was so long confined to its native soil, without spreading into distant countries; I pray him to consider, that foreign commerce was much more sparingly carried on in ancient times, than in our days, especially between mediterranean nations: and likewise that the ancients seldom or never undertook long voyages by sea, as we do. And *Ludolfus* observes, that the *Ethiopians* in particular were ignorant of mercantile affairs¹. Therefore, when in process of time the mutual intercourse of different nations became more frequent by wars, trade, and other causes; this contagious disease was spread far and wide. But towards the end of the eleventh century, and in the beginning of the twelfth, it gained vast ground by means of the wars waged by a confederacy of the *Christian* powers against the *Saracens*, for the recovery of the *Holy land*; this being the only visible recompence of their religious expeditions which they brought back to their respective countries. From that time forward, wheresoever this most infectious distemper once got a footing, there it has obstinately held uninterrupted possession. For the purulent matter, which runs out of the pustules, being caught in the bed-cloaths and wearing apparel of the sick, and there drying and remaining in-

visible, becomes a nursery of the disease, which soon breaks forth on those who happen to come in contact with it; especially if the season of the year and state of the air be favourable to its action.

In this place it may not be improper, in confirmation of the foregoing doctrine, to relate the following fact, which was attested to me by a gentleman of great experience, who had been for many years governor of *Fort St. George* in the *East Indies*. While he was in that post, a *Dutch* ship put into the *Cape of Good Hope*, some of the crew of which had had the small pox in the voyage thither. The natives of that country, who are called *Hottentots*, are so wild and stupid that they might seem to be of a middle species between men and brutes; and it is their custom to do all servile offices for the sailors, who land there. Now it happened, that some of these miserable wretches were employed in washing the linen and clothes of those men, who had had the distemper; whereupon they were seized with it, and it raged among them with such violence, that most of them perished under it. But as soon as fatal experience had convinced this ignorant people that the disease was spread by contagion, it appeared that they had natural sagacity enough to defend themselves. For they contrived to draw lines round the infected part of their country, which were so strictly guarded, that if any person attempted to break through them, in order to fly from the infection, he was immediately shot dead. Now this fact seems the more remarkable, as it evinces, that necessity compelled a people of the most gross ignorance and stupidity to take the same measure, which a chain of reasoning led us formerly to propose, in order to stop the progress of the plague²; and which, some time after, had a happy effect not only in checking, but even entirely extinguishing that dreadful calamity in *France* where it broke forth, and threatened the rest of *Europe* with destruction.

1. *Hist. Aethiop. Lib. iv. cap. vii.*

2. *Discourse on the Plague*, Part ii, chap. 2, p. 109.

NEW PREPARATIONS AND APPLIANCES

PIPEROXANE: A NEW DIAGNOSTIC AGENT

Piperoxane is the common name for piperidylmethyl benzodioxane hydrochloride. It is an adrenolytic agent capable of inhibiting the effect of circulating adrenaline on the blood pressure, and so affording a diagnostic test for the presence of tumours of chromaffin tissue, or pheochromocytoma.

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ASSOCIATION NEWS: VERENIGINGSNUUS

SIGNING OF DEATH CERTIFICATES BY INTERNS*

To Honorary Secretaries of all Branches and to Federal Council Members for information:

Federal Council members will recall that at the meeting of the Council held in Johannesburg in October the question was raised whether interns were legally entitled to sign death certificates. An urgent telegram to the Registrar of Births, Marriages and Deaths received no reply. The Medical Secretary, on a visit to Pretoria after the meeting, was in touch with the Registrar who informed him that legal opinion had been taken by the Department of the Interior and that he understood that the legal opinion was against interns signing death certificates. He stated that he would let the Medical Secretary know the position as soon as it had been clarified.

The Medical Secretary addressed a reminder to the Registrar on 15 November and has now received the following letter in reply, dated 30 November:—

"In reply to your letter of 15 November 1950, I have to inform you that the Births, Marriages and Deaths Act, Act 17 of 1923, provides for the signing of death certificates by registered medical practitioners only.

Although interns may describe themselves as medical practitioners, they are not registered medical practitioners and they are therefore not qualified to sign death certificates."

This is sent to you for information, with the request that it be made known to those in charge of hospitals and interns in your Branch area.

Medical House,
Cape Town.
4 December 1950.

A. H. Tonkin,
Medical Secretary.

[* In order to assist the interns, Honorary Medical Officers and others are asked to see that statutory death certificates are completed and signed in accordance with the Births, Marriages and Deaths Act, Act No. 17 of 1923.—Medical Secretary.]

PASSING EVENTS

The Government Gazette of 1 December 1950 contains the following Notice (No. 2979):

JUDICIAL COMMITTEE OF INQUIRY.—OPERATIONS OF LEUCOTOMY AND THE VARIOUS COMA AND SHOCK TREATMENTS

It is hereby notified for general information that the Minister of Health has appointed the undermentioned persons to be members of a Committee of Enquiry with the following terms of reference:—

To enquire whether it is necessary for a competent person or persons to be appointed to give or withhold consent for the operation of Leucotomy to be performed for mental reasons or

pain as well as the various coma and shock treatments in the cases of certified or non-certified persons and to report:—

(1) on the nature of the operator performed or the shock or coma administered;

(2) on the immediate results and dangers to the patient both mental and physical;

(3) on the subsequent results and dangers to the patient, both mental and physical;

(4) in the case of persons certified under the Mental Disorders Act No. 38 of 1916, as revised by Act No. 7 of 1944, as to the legal powers of the Physician Superintendent of the Hospital or Institution in which the patient is detained with regard to his consent;

(5) as to the relationship of the Physician Superintendent to the various relatives of the patient in regard to consent;

(6) in the case of non-certified patients as to who may give consent—the patient or which of the relatives; and to make recommendations relative to any of the above aspects or any other matters relating thereto which the Committee may consider necessary or desirable and if it is decided in both or either of the types of cases mentioned that a competent person or persons should consent to make recommendations then as to how this should be arranged.

The Committee is empowered to call for any documentary evidence necessary and to take evidence from such persons as is desired.

Honourable Mr. Justice Charles Edward Barry (retired).
Ian Reginald Vermooten, Esq., M.R.C.S., L.R.C.P., Physician Superintendent, Weskoppies Hospital, Pretoria, and Deputy Commissioner for Mental Hygiene.

Frederick Charles Silk, Esq., B.A., LL.B., Senior Grade Magistrate, Department of Justice.

The Minister has further appointed the Honourable Mr. Justice Charles Edward Barry to be Chairman of the Committee and Mr. F. R. Klerck of the Department of Health to act as Secretary.

The Committee will commence its deliberations early in 1951 and any person desiring to give evidence should communicate forthwith with the Secretary, P.O. Box 386, Pretoria, stating briefly the nature of such evidence.

INTERNATIONAL CLASSIFICATION OF THE STAGES OF CARCINOMA OF THE UTERINE CERVIX

A Committee of duly appointed representatives of the Section of Obstetrics and Gynecology of the American Medical Association, the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, and the American Gynecological Society, meeting in session with the Editorial Committee of the Annual Report on the Results of Radiotherapy in Carcinoma of the Uterine Cervix on the occasion of the International and Fourth American Congress on Obstetrics and Gynecology at New York City on 14-19 May 1950, has agreed to propose the following modification of the classification adopted by the Health Organization of the League of Nations in 1937:

Stage 0: Carcinoma *in situ*—also known as pre-invasive carcinoma, intra-epithelial carcinoma and similar conditions.

Stage 1: The carcinoma is strictly confined to the cervix.

Stage 2: The carcinoma extends beyond the cervix, but has not reached the pelvic wall. The carcinoma involves the vagina, but not the lower third.

Stage 3: The carcinoma has reached the pelvic wall. (On rectal examination no 'cancer-free' space is found between the tumor and the pelvic wall.)

The carcinoma involves the lower third of the vagina.

Stage 4: The carcinoma involves the bladder or the rectum, or both, or has extended beyond the limits previously described.

It was resolved that this classification be termed the International Classification of the Stages of Carcinoma of the Uterine Cervix, and that all organizations concerned with the problem on hand be approached to consider its adoption.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

At a Quarterly Meeting of the College held on Tuesday, 7 November, the President, Sir David K. Henderson, in the chair, the following were elected Fellows of the College: Iain C. Macdonald, M.D. Edin.; Robert B. McMillan, M.D. Glasg.

The following were elected Members of the College: Benjamin W. Anderson, M.D. St. And.; Andrew A. H. Gailey, M.D. Bell.; Syed A. Mannan, M.B. Osmania; Mir Mousiquidin, M.B. Osmania; Pondicherry R. Mohan, M.B. Rang.; Andrew W. Lees, M.D. Glasg.; William L. H. Jackson, M.B. N.Z.; Shafica A.K. Karagulla, M.D. Beirut; Edwin D. Levittan, M.D. Dalhousie; James F. McHarg, M.B. Edin.; Alric B. Da Costa, M.B. Edin.; Doddaballapur L. Murri Rao, M.B. Mysore; Ronald F. Brooks, M.B. Bristol; Abdel A. A. El Sherif, M.D. Cairo; Stanley E. Large, M.B. Cantab.; Robert J. C. Southern, M.B. Edin.; Robert D. Young, M.B. Edin.; James B. Clark, M.B. Glasg.; Norman K. Smith, M.B. St. And.; Michael F. G. Buchanan, M.B. Edin.; John A. McConachie, M.B. Aberd.; Robert L. Richards, M.D. Aberd.; Ian S. Collins, M.B. Sydney; T. Lindsay Henderson, M.B. Edin.; N. H. Dalal, M.D. Bomb.

The Hill-Pattison Struthers Bursary was awarded to Alan Fennell Bushby.

A presentation was made to Mr. T. H. Graham, O.B.E., on his retirement after 40 years' service as Librarian of the College.

MEDICAL PRACTITIONERS AND IMPORT CONTROL

Medical practitioners are reminded that the importation of drugs, instruments, etc., is not exempt from the general rules applying to import control. The Customs authorities are not in a position to clear any importations unless the importer provides the appropriate import permit.

Practitioners who desire to make purchases overseas should, in the first instance, apply to the Convener, Medical Advisory Committee, P.O. Box 643, Cape Town, for the necessary permit. The Medical Advisory Committee will make the necessary representations to the authorities, if the permit is to be recommended. If practitioners follow this procedure they will find that the importation of their instruments, drugs, etc., is considerably facilitated.

An application to the Medical Advisory Committee should state the name and address of the overseas supplier, the precise nature of the drugs or instruments to be imported, the precise amount of currency required and the name and address of the importer's South African bank.

THE SCREENING COMMITTEE ON THE USE OF RADIO-ISOTOPES

1. The Atomic Energy Board, constituted in terms of the Atomic Energy Act No. 35 of 1948, has laid down that no person or institution may import or handle radio-active isotopes except through its appointed agents.

2. The Atomic Energy Board has appointed the Council for Scientific and Industrial Research to act as agent.

3. The Council for Scientific and Industrial Research has established a Screening Committee to scrutinize applications for radio-active isotopes.

4. The Committee (as of November 1950) consists of the following members:—

Dr. E. Jacobs—Head of Radiotherapy Department, Pretoria General Hospital.

Dr. J. Kave—Head of Radiology Department, Johannesburg General Hospital.

Dr. M. Weinbren—Radiotherapist, Johannesburg.

Dr. S. M. Naudé—Vice-President, Council for Scientific and Industrial Research (Chairman).

Dr. E. C. Halliday—Principal Research Officer, National Physical Laboratory (C.S.I.R.).

Miss T. Alper—Head of Biophysics Section, National Physical Laboratory (C.S.I.R.).

Prof. S. Oosthuizen—Head of Radiology Department, Pretoria General Hospital, is entitled to attend meetings in his capacity as Secretary of Medical Research, Council for Scientific and Industrial Research.

5. The following general principles have been laid down by the Screening Committee:—

(a) Applications for radio-isotopes will be approved where their use may be beneficial and as long as some control can be exercised over handling and measurements. In general, applications for ^{131}I for tracers or for therapy should be approved only if arrangements for making measurements are satisfactory.

(b) The therapeutic use of radio-isotopes should be permitted only on patients who are under the care of a registered radio-therapist, or registered radiologist devoting his time to radiotherapy.

(c) It is very desirable that patients who receive therapeutic doses of radio-isotopes should be hospitalized in order that excreta may be collected for measurement, where necessary, and also for safe disposal. Where patients are hospitalized proper arrangements for the collection of excreta should be made.

(d) Radiotherapists responsible for the administration of radio-isotopes to patients should from time to time submit to the Screening Committee reports on their cases.

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

The following candidates have completed all the requirements of the Sixth Professional Examination for the degree of M.B., B.Ch.:—

Allan, B. M.; Alldis, D. Ballantyne, P. D.; Bear, J. N.; Bensusan, A. D.; Bloom, M. L.; Blumberg, N. A.; Borok, G.; Brebner, D. M.; Brymer, A.

Carey, F. M.; Caro, C. G.; Chappell, S. L.; Cope, E. Dawber, V. C. F.; de Bruin, J.; de Kock, C. J. G.; de Vos, W. N.; Dickson, D. N.; Dunning, E. K.

Edelstein, J.; Eidelman, A.; Eyre, J. Fitz-Patrick, I. G.; Freiman, I. Goldberg, C. H.; Gollach, M.; Grant, C.

Houghton, J. W. Isaacs, H.; Isdale, J. M. Jenkinson, W. E. O.; Joos-Vandewalle, L. J.

Kaplan, I.; Khan, A.; King, B. A.; Knowles, S. L.; Kushlick, E.

Lachman, S. J.; Lazarus, J. H.; Leitch, A. H.; le Roux, P. R.; Lewis, J. B.; Lewis, P. J.; Lissos, D. E.; Lorentz, T. G.; Lyons, E. D.

Malherbe, L. F.; McKechnie, J. K.; McKenzie, J. M. M.; McPhail, A. V.; Meyer, T. C.; Moir, P. M.; Morley, E. C.; Muir, R. D.

Newborn, E. C. Oetlé, T. H. G. Pfaff, M. D.; Pienaar, P.; Piesold, G. A. F.; Potasnick, A. A.

Pottinger, D. A.; Proctor, L. C.; Promnitz, D. N. Rabie, N.; Rabinowitz, E.; Reef, J.; Rencken, A. L.; Richards, R. R.; Richter, M. B.; Rom, J.; Ryan, H. B.

Shaw, C. C.; Short, R. C.; Smithers, J. H.; Spicer, H. W. R.; Stein, I.; Symon, M.

Tennant, G. B.; Thomas, S. P. M. Van Amerongen, A. J.; van Schalkwyk, J. B.; van Schalkwyk, S. J.; van Zyl, J. A. V.; Viljoen, J. J.

Waghmarae, D.; Watermeyer, M.; Welchman, J. M.; Welsh, R. I. H.; Wertheim, L. M.; Whittington-Wirford, G. L. St. J.; Wille, A. M.

Yoffe, Y.

REVIEWS OF BOOKS

TUBERCULOSIS CONTROL

Tuberculosis Control in a British Colony. By Vincent Hetred, M.B., B.S. (Lond.). Medical Officer, Nigeria. (Pp. 50 + map of French West Africa. 7s. 6d.) London: National Association for the Prevention of Tuberculosis.

Contents: 1. Approach to the Problem. 2. Aims and Methods of Investigation. 3. The Provincial Survey—First Stage. 4. The Provincial Survey—Second Stage. 5. Plans for Prevention and Control. Appendix.

The author sets out in a commendably realistic manner and in fair detail a proposed organization for carrying out a five-year survey to obtain full epidemiological information concerning tuberculosis in Nigeria. During this time it is suggested that no attempt at treatment be undertaken other than the establishment of a pilot unit to evaluate the clinical effectiveness of various therapeutic procedures.

In selecting the methods for carrying out the second stage of the control programme, i.e. the actual assault as distinct from the first stage of investigation, it is proposed to consider

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Progestin B.D.H. is also successfully employed in cases of threatened and habitual abortion, dysmenorrhoea without hypoplasia and 'after-pains' following childbirth. Administration is by intramuscular injection.

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such matters as housing, nutrition, isolation and medical treatment in strict relation to the funds available; the habits, beliefs and traditions of the people; the aptitude and ability of Native health personnel, and the availability of expert European medical staff.

The interesting description of Nigerian Native life demonstrates many points of resemblance between Central and South African conditions and strongly supports the idea of a Pan-African health approach.

This booklet should be carefully studied by all agencies dealing with tuberculosis in the Union.

MAN—A MICROCOSM

Man is a Microcosm. By J. A. V. Butler. (Pp. 152 + xii, with 15 illustrations and eight plates. 10s. 6d.) London: MacMillan & Company Limited. 1950.

Contents: 1. Life in the Universe. 2. The Building Stones and the Fabric. 3. Mediators Between the Living and the Non-Living. 4. Helpers and Hinders of Vital Processes. 5. How Proteins are Made. 6. Life Goes On. 7. Inside the Cell. 8. Chemical Controllers of the Body. 9. Development and Growth. 10. How did it all Begin? 11. Muscle and Brain. 12. Action and Free Will. 13. Speech and Thought. 14. Is the Brain a Calculating Machine? 15. The Nature of Man. Index.

The general reader and workers in all branches of science will find in this book a broad survey of what has been achieved in scientific discoveries of the nature and basis of living matter. A description is given of atoms and molecules; proteins and enzymes; nucleoproteins, which occur in viruses and chromosomes; and living cells, from the smallest independent unit to man with his millions of cells.

The extraordinary complexity of living matter has been studied by scientists of many kinds, and the great advances in our knowledge of proteins, enzymes, vitamins, viruses, genes and the functions of these bodies are described in a stimulating fashion.

An interesting account is given of the modern views on the way the brain works. The list of plates reveals the special techniques involved in modern studies, e.g. the photographs of crystals of pepsin, ribonuclease, and hexokinase, and the attack of a bacterium by bacteriophage. There are also numerous interesting text illustrations.

Medical practitioners who read this book will find it most enjoyable and exciting, and will be better equipped to explain to others lacking the proper background the modern scientific thought and picture of life and human nature.

SQUINT

Worth and Chavasse's Squint: The Binocular Reflexes and the Treatment of Strabismus. By T. Keith Lyle, C.B.E., M.A., M.D., M.Chir. (Cantab.), M.R.C.P. (Lond.), F.R.C.S. (Eng.). (Pp. 319 + x. With 208 figures. Eighth edition. 35s.) London: Baillière, Tindall & Cox. 1950.

Contents: 1. Introduction. 2. The Foundations of Binocular Reactions—Structural (Anatomical) Factors. 3. The Foundations of Binocular Reactions—Physiological Factors (The 'Binocular Reflexes'). 4. Structural Development of the Eyes and Orbit in the Child. 5. Reflex Development in the Child. 6. Introduction to the Pathology of Binocular Anomalies. 7. The Site and Nature of Obstacles in the Reflex Paths. 8. Heterophoria and Dissociation by Primary Sensory Obstacles. 9. Dissociation by Primary Motor Obstacles. 10. Accommodational and Other Squints Primarily Related to the State of the Refraction. 11. Reactions to Dissociations. 12. Inhibitions and their Sequels. 13. Secondary Correspondences. 14. The Investigation of the Deviation. 15. The Investigation of Latent Deviation (Heterophoria) (and some Remarks on Treatment). 16. The Investigation of the State of the Sensory Correspondence (The State of Binocular Vision). 17. The Investigation of the Cause. 18. The Treatment of the Cause and of the Secondary Sensory Correspondences. 19. The Treatment of the Deviation. 20. The Surgical Treatment of Different Types of Squint. Appendix: Illustrative Cases of Ocular Palsy and their Surgical Treatment. Index.

This book needs no introduction. Previous editions are well known to all ophthalmologists, though this one has been completely revised by Keith Lyle, who worthily follows in the footsteps of those great investigators of squint, Claude Worth and Bernard Chavasse. The profuse illustrations are very impressive; in some chapters they could take the place of the text. The summaries, often in the middle, and at the end of each chapter, help in crystallizing the pith of the matter dealt with.

One chapter could have done with further amplification, viz. that on the operative technique, which is just touched

upon in principle, in a similar manner to its treatment in Lyle and Jacksons, *Orthoptics*.

The prognosis of treatment is a particularly important chapter which should be read by all.

On the prophylactic side one suggestion can be brought to the notice of the profession as a whole: 'The ophthalmological examination of every new-born child, and the estimation of the refraction of every infant, say at the age of one year, are not unreasonable counsels, but are perhaps counsels of perfections only.'

On the other hand the medical profession should and can advise the ophthalmological investigation, and treatment if indicated of apparently normal infants born of squinting stock, as well as the investigation and treatment where necessary of the apparently normal younger brothers and sisters of a child who has manifested a squint.

OCULAR TRYPAOSOMIASIS

Manifestations Oculaires des Trypanosomiasis Humaines. By M. Toulant. (Pp. 104. Fr. 400.) Paris: Masson et Cie. 1950.

The author adduces that trypanosomiasis is responsible for numerous cases of blindness in tropical Africa in the light of many articles published in the French, Belgian, English and Portuguese Colonies.

She describes the characteristics of *Trypanosoma gambiense*, *Rhodesiense*, and *Cruzi* (the three trypanosomes pathogenic for man), their vectors and the symptoms they produce. In addition to the sleeping sickness due to *Trypanosoma gambiense*, which is the most widespread, there is the the East African Trypanosomiasis (*Rhodesiense*) with a more rapid course and graver eye lesions.

In general, the keratitis, irido-cyclitis and choroiditis associated with trypanosomiasis are benign and transitory, but tend to recur. The lesions of the optic nerve are grave, and may be bound up with meningo-encephalitis. Periodic ophthalmological examination of the background of the eye is useful for determining treatment in these cases. Lesions may also be due directly to the trypanosome; in these cases optic atrophy frequently results.

There is a controversy whether the pentavalent arsenicals used for treatment, Atoxyl and Tryparsamide, may not themselves cause the optic atrophy. However, the author claims that careful examination revealed a high percentage of optic atrophy before any treatment was started and that by careful regulation of dosage, chemical and biological control of the purity of the medicaments, visual trouble originating from the use of pentavalent arsenic drugs could be prevented.

The author describes the illness of Chagas (*T. cruzi*) obtaining in South America, where it occurs in a mild form. Formerly only the graver forms were recognized.

THE PSYCHOPATHIC PERSONALITY

The Mask of Sanity. By Hervey Cleckley, M.D. (Pp. 569. £2 15s. 3d. 2nd ed.) St. Louis: C. V. Mosby Company. 1950.

Contents: 1. An Outline of the Problem. 2. The Material. 3. Cataloging the Material. 4. An Attempt at Interpretation. 5. What can be done? Appendix.

One of the great pressing sociological problems of the present day is the psychopathic personality, who presents a problem which must be better understood by lawyers, social workers, teachers and the general public. Equally important is a clearer understanding of this condition by physicians and psychiatrists to whom the laity turn for advice. That the exact classification and positive diagnosis of this condition of psychopathic personality bristles with difficulties, is made very clear by Dr. Cleckley in this excellent, lucid and fascinating volume, wherein he discusses fully a subject almost completely ignored in the average textbook of psychiatry.

The psychopath—the forgotten man of psychiatry—constitutes in many cases a type from which the community cannot protect itself; nor can satisfactory facilities be found for his detention and treatment. Legally he is a paradox, since he is neither a psychotic nor a psychoneurotic, if one is to accept the usual definition of these two groups of mentally deranged peoples. But there is no doubt that he exists and

is a profound social misfit who ranges from the mere eccentric to the habitual criminal, in and out of gaol, 'woe, confusion, despair, farce and disaster . . . progressively accumulating in his social wake'. Any contribution to an understanding of this type of person must be of the greatest value and Cleaveley does full justice to his subject.

The clinical material and case histories which are presented, the discussion on the pathology, the doctrine of semantic pathology as a possible explanation and the wise suggestions about treatment, should provide a valuable stimulus to further work and research in this tremendously important field of mental disorder.

The Mask of Sanity can be recommended enthusiastically to physicians, educators, lawyers and social workers as one of the most important contributions towards the solution of a distressing social disease.

MEDICAL BIOLOGY

Practical Biology for Medical and Intermediate Students. By C. J. Wallis, M.A. (Cantab.). (Pp. 404 + x, with 214 figures. Third ed., 21s.) London: William Heinemann, Medical Books, Limited. 1950.

Contents: Preface to the First and Second Editions. Foreword to the Second and Third Editions. Introduction. 1. Microscopical Technique. 2. Elementary Biochemistry. 3. Plant Biology. 1. Plant Morphology and Histology. 2. Plant Physiology. 4. Animal Biology. 1. Animal Anatomy. 2. Animal Cytology and Histology. 3. Animal Physiology. 4. Vertebrate Embryology. Appendices. 1. The Preparation of Reagents. 2. Biological Methods. 3. Equivalents, Conversion Table. 4. Treatment of Accidents in the Laboratory. 5. Firms Supplying Biological Apparatus and Material. Index.

As stated in the preface, this is essentially a practical guide for students of elementary biology and will prove particularly useful where there is a shortage of demonstrators; but there are also many hints and techniques for the instructor and the book is well indexed for easy reference.

It covers a very wide field and includes elementary Botany and Biochemistry as well as Zoology, so that many separate courses can be extracted. The plant and animal types dealt with are naturally those common in Europe, which is a disadvantage in South African Universities where *Xenopus* naturally replaces *Rana* and *Jasus* replaces *Astacus*. This objection naturally applies to all overseas textbooks.

A special feature is the amount of space devoted to experiments on plant and animal physiology. Biology is becoming increasingly experimental in its outlook and this book provides a long-felt want in giving clear instructions for simple experiments to illustrate fundamental processes. There are also directions for the preparation of specimens for anatomical or microscopic examination; these should be useful not only to a student working on his own but to the teaching staff as well.

Throughout, the directions are clear and those on the dissection of the afferent branchial system of the dogfish are particularly good. One wishes that instructions for the dissection of some of the other types were given in equal detail. A surprising feature is the poor quality of the diagrams, since the value of a practical guide depends largely on the illustrations.

In spite of the sketches this is a very useful book. It brings together a lot of practical information which the student will not find in ordinary textbooks. Moreover it describes a number of simple physiological experiments which should be included in elementary courses of biology.

VAGINAL AND CERVICAL SMEARS

Les Frottis Vaginaux et Cervicaux. By J. Paul Pundel. (pp. 350 with 82 figures. 2,000 fr.) Paris: Masson et Cie. 1950.

This book on vaginal and cervical smears is intended to summarize work on the subject which is not well known in the French-speaking countries.

The result is an excellent review of the literature, full technical details and interpretations, and much original work by the author.

The drawings and photomicrographs are very well reproduced and there is a comprehensive international bibliography, but no index.

FEVERS FOR NURSES

Fevers for Nurses. By Gerald E. Breen, M.D. (N.U.I. Dub.), D.P.H., D.O.M.S. (R.C.P. Lond., R.C.S. Eng.). Pp. 220 + viii, with 29 figures and eight colour plates. Third ed. 7s. (6d.) Edinburgh: E. & S. Livingstone Limited. 1950.

Contents: 1. General Features of the Infective Fevers. 2. What to Observe and Report in Fever Cases. 3. Some Principles of Prevention of Communicable Diseases. 4. Drugs and Their Administration. 5. Streptococcal Infections. 6. Diphtheria. 7. Enteric. 8. Smallpox, Vaccination and Chickenpox. 9. The Respiratory Infections. 10. Infections of the Nervous System. 11. Care of the New-Born. 12. Rubella, Mumps and Influenza. 13. The Special Senses and the Skin. 14. Operative Procedures and Manipulations in Fever Nursing. 15. Examinations. Glossary. Index.

Fevers for Nurses, originally published in 1938, is now in its third edition; but before making its most welcome reappearance, Dr. Breen's textbook has been revised and, to a large extent, rewritten, with the greatest thoroughness and conscientiousness.

He has taken into account the progress in treatment and handling of infectious diseases, many of which have undergone dramatic changes during the last 12 years, and this latest edition may well be regarded as one of the most up-to-date and valuable books on this particular subject.

Dr. Breen's profound knowledge of what he writes, and his sympathetic understanding of the mentality and scope of the great majority of nurses, for whom this book is primarily intended, has made it possible for him to condense the subject to its essentials, doing away with superfluous, dialectic frills, and thus presenting his facts in a clear, plastic fashion, easy to grasp and equally easy to retain.

From a purely South African point of view, there are some omissions which make Dr. Breen's book of slightly less value to our nurses here, than to their colleagues in England. He makes no mention of typhus, plague and malaria, e.g. diseases that every nurse is apt to meet not infrequently in this country, but this is a purely local criticism of an otherwise impeccable piece of work.

With its excellent illustrations, some in colour, and its logical presentation of understandingly marshalled facts, *Fevers for Nurses* is a book that should find its way into the hands of every member of the nursing profession.

MEDICINE IN 1850

Catalogue of an Exhibition Illustrating Medicine in 1850. Publications of the Wellcome Historical Medical Museum Occasional Papers Series, No. 2. No. 1. Catalogue of an Exhibition Commemorating the Bicentenary of Edward Jenner (1949). (Pp. 63 with 9 figures. 3s.) London: Oxford University Press. 1950.

Contents: Introduction. 1. Physics. 2. Chemistry. 3. Biology. 4. Physiology. 5. Anatomy. 6. Microscopic Technique and Histology. 7. Pathology and Bacteriology. 8. Diagnostic Instruments. 9. Clinical Medicine. 10. Ophthalmology. 11. Pharmacology. 12. Therapeutics. 13. Infectious Diseases. 14. Public Health. 15. Hospitals and Nursing.

This interesting catalogue is essential for a proper appreciation of the *Exhibition Illustrating Medicine in 1850* arranged by the Wellcome Historical Medical Museum. There is an interesting and valuable introduction to the Catalogue by Prof. E. Ashworth Underwood, the Director of the Museum.

PSYCHOANALYTIC DICTIONARY

Freud: Dictionary of Psychoanalysis. Edited by Nandor Fodor and Frank Gaynor. (Pp. 208 + xii. \$3.75.) New York: The Philosophical Library, Inc. 1950.

Many people have been so dismayed by psychoanalytic terminology, and made so uneasy by the apparently bizarre words which Freud applied to his concepts (penis-envy, totemism, sadistic-anal phase, castration complex, etc.) that they have been unable to read Freud's work in the original, and have had to resort instead to the simplified versions prepared by various sympathizers and commentators.

Freud wrote in an alert and often brilliant manner; much of his distinction lies in the clarity of his thought, the boldness of his intellectual attack and the breadth of his culture. It is obviously advantageous to be able to read the 13 remarkable books Freud wrote, rather than the graceless and sometimes

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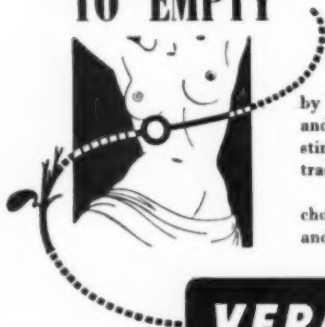
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inaccurate versions of his interpreters. This dictionary has accomplished a great deal if it assists more people to read Freud more intelligently. The basic concepts of psychoanalysis are defined by quotation from the original works, and the volume is indicated from which each definition is taken.

The book is a glossary. As such its value is restricted but nevertheless definite. It serves to make psychoanalytic terms more accessible; but never accessible enough, one hopes, to be used by the pretentious to festoon everyday speech.

RADIOLOGICAL DIAGNOSIS

A Text-Book of X-ray Diagnosis, Vol. III. By British Authors. In four volumes. Edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E. (Pp. 830 + xvi, with 694 illustrations. Second ed. 70s.) London: H. K. Lewis & Company, Limited. 1950.

Contents: Part I: Alimentary Tract. 1. The Salivary Glands. 2. The Pharynx and Oesophagus. 3. Stomach, Duodenum and Diaphragm. 4. Small Intestine, Appendix and Large Intestine. 5. The Alimentary Tract in Infants and Children. Part II: Biliary Tract. Part III: The Abdomen. Part IV: Radiology in Obstetrics. 1. The Antenatal Study of the Foetus. 2. The Obstetric Pelvis and the Study of Foetal-Pelvic Proportions and Relationships. 3. The Radiology of the Soft Tissues and the Placenta. 4. The Urinary Tract in Pregnancy. Part V: Gynaecological Radiology. Part VI: Urinary Tract. Index.

The first edition of this book established a standard for radiological textbooks that has since not been surpassed. This volume has been almost completely re-cast and re-written. The text of nearly every chapter has been expanded and the number of reproductions increased. Nevertheless the concise and eminently practical approach characterizing the previous edition has been retained.

This volume, unlike most textbooks that are behind the times as soon as they are published, is completely up to date.

Although one has no criticism to make, one would offer the suggestion to the publishers that the volumes be subdivided further so that the sections on obstetrics and gynaecology may be made available in one volume for specialists in these fields and the section on urology be available to the urologists.

Omissions are few, and where they occur they are mostly insignificant, e.g. there is no mention of colonic lavage in the preparation of a patient for an intravenous pyelogram, and the use of hyaluronidase is not mentioned in connexion with intramuscular pyelography. In the section on the alimentary tract in infants and children a little more detail of the technique in the examination would be appreciated.

The trivial nature of these criticisms is evidence of the high standard maintained throughout this volume, but as it has been written by a panel of 17 leading British teachers of radiology, this high standard was to be expected.

This book is essential to any radiologist, and it is worthy of very careful inspection by anyone interested in the subjects indicated in the table of contents.

CORRESPONDENCE

REGISTRATION OF MEDICAL AUXILIARIES

To the Editor: As President of the Cape Province Branch of the South African Society of Physiotherapists I wish to state that this Society does not associate itself with the objectives reported in the *Cape Times* of 1 December 1950.

For the 25 years of its existence its policy has been to work for State registration, with one of the conditions of registration being that treatment be undertaken only under instructions from a medical practitioner.

M. C. Haggart.

Glencoe
Talana Road,
Claremont.
1 December 1950.

DERMATOLOGISTS AND RADIO-THERAPY

To the Editor: It came as a pleasant surprise to me that in Dr. Weinbren's latest letter there has been a retreat from the original position. In his first letter Dr. Weinbren argued against the practice of any radiotherapy by dermatologists. Now he merely wishes to limit the dose vouchsafed to us to 450 r with the proviso that this is not multiplied a sufficient number of times to destroy a rodent ulcer. This is indeed a concession, but I must again complain about some peculiarly unguarded statements. Here are a few examples:—

1. 'I could not discover any University or other institution which gives a diploma in dermatology.' This is indeed a strange oversight. The Edinburgh M.R.C.P. can be written with dermatology as a speciality. There are similar diplomas in Glasgow and Dublin. There is a diploma in dermatology in America. At the University of the Witwatersrand an M.D. can be written in dermatology.

2. 'I could not discover any institution which gives any certificate of competence as far as X-ray therapy is concerned.' 'I could not discover any institution which gave organized practical instruction in the use of X-ray therapy.' If Dr. Weinbren would like to see a certificate signed by the Professor of Dermatology in Edinburgh to the effect that practical experience in the use of X-ray therapy was acquired in the Skin Department of the Royal Infirmary, I shall be glad to show him one.

3. 'Dr. Gordon makes a great point that McKee and Cipollaro, dermatologists, have written a book on the subject of X-ray therapy.' This is taken out of its context. Dr. Weinbren knows quite well that the point I made was that this book was written *for dermatologists*.

4. 'At Liverpool dermatologists are not allowed to treat malignant conditions.' Must we understand that there is some statute which prohibits a dermatologist from treating a rodent ulcer in Liverpool? Perhaps it is only a Municipal by-law.

5. 'In none of these hospitals is the dermatologist allowed to treat a malignant skin condition, whether it is a rodent ulcer or any other type of malignancy.' (This applies to some London hospitals.) As stated, this means that a dermatologist is not allowed to treat a rodent ulcer by diathermy or excision. I am sure that Dr. Weinbren is overstating his case for effect. Personally, I cannot recollect any decree, regulation, or ukase which prohibits a member of the visiting staff of a London hospital from treating any case in his department by any method he chooses to adopt.

6. 'At Edinburgh . . . the dermatologists only prescribe doses up to a total of 450 r. . . . In my days in Edinburgh Professor Percival used to prescribe 1,500 r for plantar warts. It would seem that he is not allowed to do so any more. This is surprising in view of the fact that he recommends X-ray therapy for plantar warts in his textbook. I rather think that Dr. Weinbren should modify this statement.

7. 'It would appear then, as far as Australia and Britain are concerned, although some institutions permit dermatologists to treat benign conditions, under the supervision of the radio-therapist, up to a certain level of dosage. . . . Did either Dr. Barber or Professor Percival authorize this fantastic statement? The spectacle of the Grant Professor of Dermatology doing X-ray therapy under supervision should be worth seeing!

8. 'Dr. Gordon also appears to have overlooked that Dr. Leeming, who started this correspondence, agreed that dermatologists should not treat malignant disease.' At what stage in this argument did I declare myself bound by Dr. Leeming's statement?

On the whole I found Dr. Weinbren's researches a little selective. In a search ranging from Sweden to Australia he seems to have found half a dozen people who agreed with him that dermatologists should not treat rodent ulcers. If he wanted to meet dermatologists who do their own X-ray therapy, including rodent ulcers, I could have introduced him to a hundred or so in Britain or America any day of the week. The fact that Dr. Weinbren took his search as far afield as Sweden and Australia, but failed to investigate the position in America, is also rather curious. Perhaps the fact that American dermatologists are such keen and competent radio-therapists acted as a deterrent. Dr. Weinbren is positively lyrical about the arrangements in Sweden, but not a word does he say about

the truly great dermatological institutions in France and Denmark. Dr. Weinbren does not appear to have found anybody, outside Sweden, who thought that dermatologists should not do any X-ray therapy at all. In view of the fact that in his last letter Dr. Weinbren questioned the competence of dermatologists to do any kind of X-ray therapy, a clear admission of this fact would have been a graceful gesture. Dr. Weinbren also fails to make it clear that all his researches apply to institutional practice only. As his original remarks applied very definitely to private practice, he would have been stating his case more fairly now if his inquiries overseas, including Sweden, had embraced private practice as well.

S. Gordon.

504 Medical Centre,
Jeppe Street,
Johannesburg.
4 December 1950.

A CASE OF NEUROFIBROMA

To the Editor: The interest of this unusual case lay in the diagnosis. The patient had a fluctuant swelling within the right orbit (Fig. 1). It had increased during the previous five years.



Fig. 1.

The 'abscess' had been drained in hospital with only temporary improvement, two years before I saw him.

After my examination, fluid resembling pus was aspirated. It consisted of amorphous debris with no pus cells.

At operation the lateral wall of the orbit was removed to expose the mass. The tumour consisted of a thin outer wall containing yellow fluid in which lay an oval mass two inches long. Both the outer wall and the oval mass were shown microscopically to be neurofibromatous. The fluid was presumed to be due to necrotic degeneration of the tumour.

The patient made an uneventful recovery and returned to work within a month, much improved in appearance and retaining some vision in the right eye.

J. Graham Scott.

Johannesburg,
6 December 1950.

GASTRO-ENTERITIS IN INFANTS

To the Editor: Some time ago I wrote to you about the remarkably good results I had had in gastro-enteritis in infants by treating them with a single initial dose of Tinct. Opium and then giving them Sulphadiazine and Kaolin. My results in this condition have continued to be exceedingly good.

Since 1 June 1949 up to the present date, I have treated more than 200 cases of vomiting and diarrhoea in infants and young children with, as far as I can ascertain, only one death. This child was 14 years old and he had had dysentery for two weeks before he came under my treatment. He was given

Sulphaguanidine and Kaolin and he died four days after treatment began.

The other patients had had vomiting and/or diarrhoea, with blood in the stools in some cases for periods varying from 24 hours to several weeks. They were practically all treated by their mothers at home.

My routine treatment was: Tinct. Opium, $\frac{1}{2}$ drop *statim* for babies between 3-6 months. Repeated in 24 hours, if necessary. Tinct. Opium, 1 drop *statim* for babies between 6 months-2 years. Sulphadiazine, $\frac{1}{2}$ tablet (1 tablet is 0.5 gm.) 4-hourly for 8 doses for babies under six months of age. Repeated, if necessary. Sulphadiazine, $\frac{1}{2}$ tablet 4-hourly for babies from 6 months-two years of age. Total, 4 tablets, usually. Kaolin, $\frac{1}{2}$ drachm three times a day for a baby under six months, for 1-2 days. Kaolin, 1 drachm three times a day for a baby over six months, for 1-2 days.

If the baby has been vomiting, he is given boiled cool water with a teaspoon for 16 hours and thereafter he is breast fed. The vast majority of my patients have been Bantu and Coloured babies and hence most of them are breast fed for at least nine months to one year. I ascribe a great deal of my success to the fact that these babies have been breast fed. For gastro-enteritis in infants there is no food to equal breast milk.

If there is no vomiting and the baby has not been weaned, breast feeding only is advised. There is no need for an initial period of starvation for 16 hours with water only. When the diarrhoea has been controlled, if the baby has been given carbohydrate foods, these are gradually introduced again. In the case of Bantu and Coloured babies the chief carbohydrate food used is mealie-meal porridge made with water and given without milk.

If the baby has been weaned and is not given breast milk at all, he is given boiled cool water administered with a teaspoon for 16 hours in the case of vomiting and diarrhoea. Then in the case of the poor Bantu infant he is given thin mealie-meal porridge without any milk for 24-48 hours. Thereafter, milk may be added, either skimmed or unskimmed, according to the vomiting and diarrhoea. Mealie-meal appears to be a very digestible food which does not irritate the bowel and stomach.

Recently, I have given up using Kaolin and now I simply use Tinct. Opium and Sulphadiazine with equally good results. However, I wish to treat many more patients without Kaolin before I satisfy myself that it need not be given, even in cases of dysentery. I also used Sulphaguanidine in cases of vomiting and diarrhoea where there was no pyrexia, but I am now replacing it with Sulphadiazine, especially in cases where there is blood in the stools.

The vast majority of patients I see with vomiting and diarrhoea have an upper respiratory tract infection, usually an acute tonsillitis or pharyngitis. Some of them have a bronchial catarrh or a bronchitis and a few have pneumonia. Where Sulphadiazine fails in the latter condition, penicillin is given.

I ascribe the good results in these cases of vomiting and diarrhoea and dysentery to the following factors:—

1. The vast majority of patients have been breast fed.
2. An initial dose of Tinct. Opium inhibits the excessive peristalsis.
3. Sulphadiazine overcomes the primary infection.
4. An initial rest of 16 hours for the stomach in a case of vomiting allows the vomiting to stop.
5. Cool, boiled water administered with a teaspoon for 16 hours provides the infant with fluid and does not over-fill or irritate the over-sensitive stomach.
6. Most patients were not dehydrated.

Although Tinct. Opium is a dangerous drug and must be used with caution, there were no ill effects (such as marked drowsiness or coma) in these patients. I administer the Tinct. Opium myself, diluting it with a teaspoonful of water and I personally repeat the dose after 24 hours if I consider it necessary. In many of the cases the diarrhoea ceased within 12-24 hours and the vomiting in an equally short time.

F. A. Lomax.

Johannesburg Building Society Building,
91 Cross Street,
Kroonstad.
9 December 1950.

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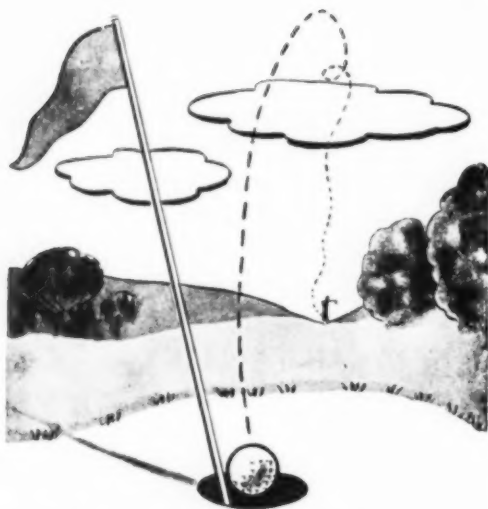
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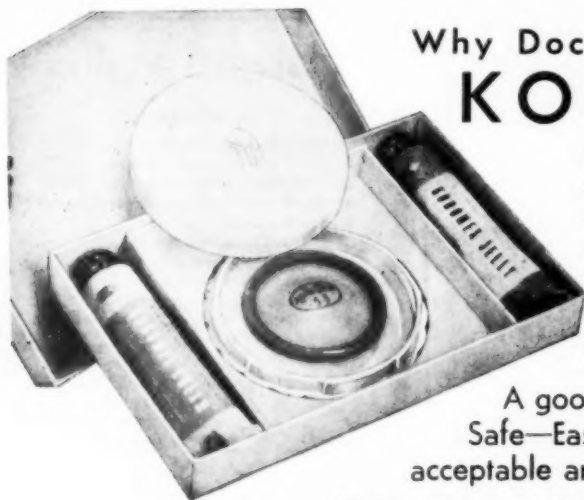
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